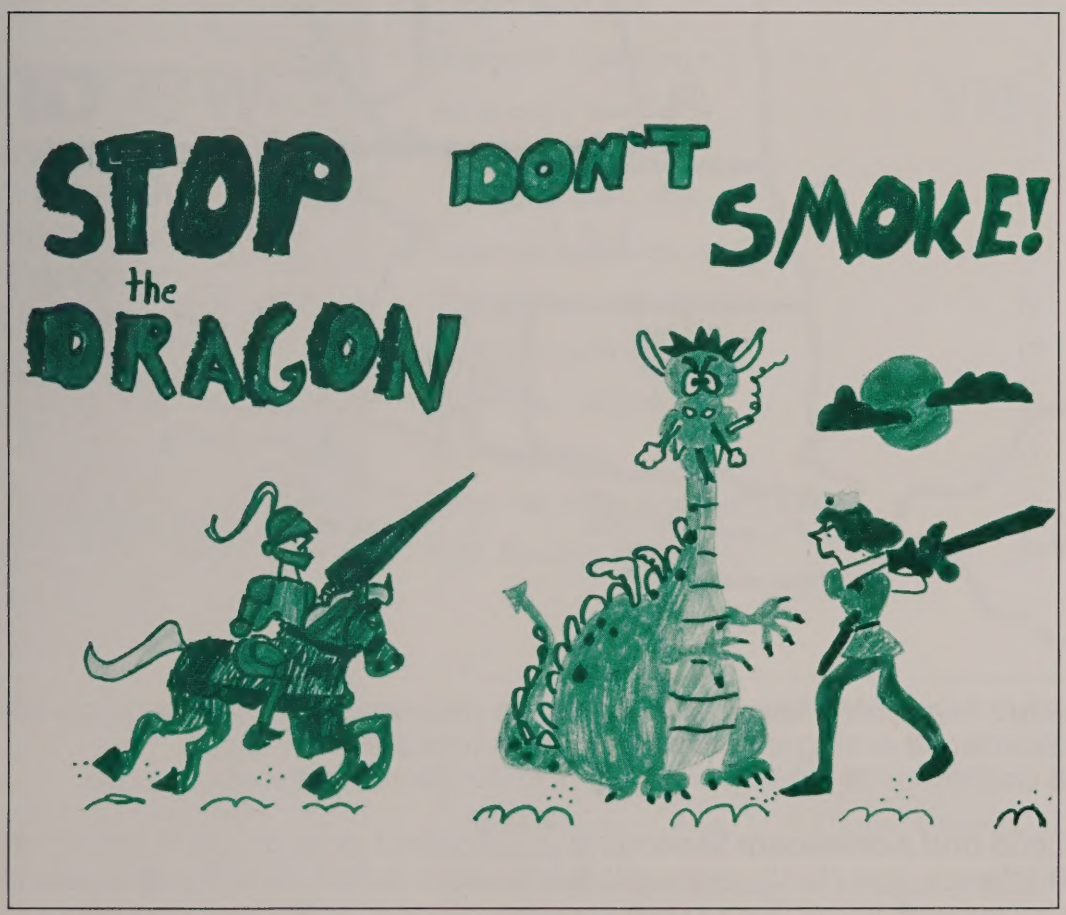
Bulk Rate
U.S. Postate
PAID
Springfield, MA
Permit No. 369

THE Hampden Hippocrat

MAY—JUNE 1992



Smoke-Free Contest Winning Poster
Jacqueline Tourigny, Grade 3, Memorial School

General Surgery

The Hampden Hippocrat
1111 Elm Street
West Springfield, MA 01089

ADDRESS CORRECTION REQUESTED

Brattleboro Retreat

Excellence in treatment since 1834

we are

a comprehensive psychiatric and addiction treatment center offering highly specialized programs

Adult Psychiatric Services ■ affective disorders ■ borderline personality disorders ■ eating disorders ■ acute suicidal ■ older adult ■ depression ■ schizophrenia ■ anxiety disorders ■ sexual abuse

Child and Adolescent Services ■ alcohol and drug abuse ■ eating disorders ■ latency age (6–12 year-olds) ■ attention deficit disorders ■ residential programs ■ recreational and vocational services ■ Meadows School, accredited special education and junior/senior high school

Adult Addictions Services ■ dual diagnosis (substance abuse and psychiatric illness) ■ alcohol and drug rehabilitation

A non-profit hospital and treatment center

Affiliate of Dartmouth Medical School

Brattleboro Retreat

75 Linden Street, P.O. Box 803, Brattleboro, Vermont 05302-0803
For referral/information, call Director of Admission, toll free, **1-800-345-5550**

Carol L. Nystrom
Executive Secretary

Donna Zitka
Membership Secretary

OFFICERS

Mark J. Mullan, *President*
Robert V. Chircop, *President-Elect*
Francis D. Horrigan, *Vice President*
Robert L. Goodman, *Secretary*
Alfred G. Garcia, *Assistant Secretary*
John R. S. Remsberg, *Treasurer*

EXECUTIVE COMMITTEE

Mark J. Mullan
Robert V. Chircop
Francis D. Horrigan
Joseph P. Keenan
John R. S. Remsberg
Robert L. Goodman
Alfred G. Garcia
Gregory A. Slachta

1992
Alicia M. Ross
Daniel Dress

1993
Kenneth M. Frankel
Daniel Teres

1994
Charles W. Cahill
Brigid K. Glackin

EX-OFFICIO HOSPITAL REPRESENTATIVES

Terry D. Ryan — Baystate Medical Center
Alicia M. Ross — Holyoke Hospital
Ludlow Hospital
Mary Lane Hospital
Robert L. Goodman — Mercy Hospital
Richard K. Douglas — Noble Hospital
R. Gopal Malladi — Providence Hospital
Peter S. Greene — Wing Memorial Hospital

CHAIRPERSON OF COMMITTEES

R. Gopal Malladi, *Auditing*
Mark J. Mullan, *By-Laws, Pro Tem*
Carl W. Janovsky, *Education*
Aaron M. Leavitt, *Impaired Physicians*
Lorne C. Smith, *Insurance*
Daniel Dress, *Legislative*
Kenneth M. Frankel, *Mediation*
Lester Frank, *Medico-Legal Affairs*
Peter T. Demos, *Medico-Religious Affairs*
Robert V. Chircop, *Membership*
Daniel Teres, *Nominating*
Francis J. Riley, *Public Health*
Alfred G. Garcia, *Public Relations*
William B. Coen, *Scholarship*
Walter F. Tauber, *Tax Supported Medical Care*

COUNCILORS

Augusto G. Asinas
William J. Baker
John J. Bandeian
Charles W. Cahill
Alphonse F. Calvanese
David M. Chadbourne
Robert V. Chircop
Daniel Dress
E. Deborah Gilman
Alan M. Harvey
Samuel Hellerman
Donald J. Higby
Francis D. Horrigan
Joseph P. Keenan
Thomas F. McCarthy
Paul T. Moore
John J. Papale
Francis J. Riley
Michael H. Rosen
Terry D. Ryan
Robert C. Shepard
Gregory A. Slachta
Lorne C. Smith
Philip B. Stoddard
Walter F. Tauber
William W. Walthall, Jr.
Murray Watnick
Nancy L. Weiss

EX-OFFICIO

John C. Ayres
Allen S. Johnson
James J. Siragusa, Jr.
Mark J. Mullan
Robert L. Goodman

THE
Hampden Hippocrat
MAY—JUNE 1992

In This Issue

Smoke-Free Poster Contest—
On Our Cover 2

Hampden Committee Activities 3

President's Message 4

Changes and Challenges in
Surgical Education 6

Laparoscopic Surgery 8

The Town-Gown Syndrome 10

Editor's Comment 17

Trust Your Partner 18

In Memoriam 21

From the MMS Regional Office 22

New Members Welcome 23

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

PAST EDITORS: Max Millman, M.D., John C. Ayres, M.D., Walton E. Stevens, M.D., Vivian M. Purdy, Walter J. Pacosa, M.D., William J. Baker, M.D., Terry D. Ryan, M.D., Nicholas P. W. Coe, M.D.

EDITORIAL BOARD: Brigid K. Glackin, M.D., Donald J. Higby, M.D., Gulabchand K. Shah, M.D.

THE HAMPDEN HIPPOCRAT is published bi monthly by The Hampden District Medical Society Springfield, MA. Acceptance of Advertising in the HIPPOCRAT does not imply endorsement. The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated. All communications should be addressed to Carol L. Nystrom, Hampden District Medical Society, 1111 Elm St., West Springfield, MA 01089: Telephone: 736-0661. To be assured of uninterrupted delivery of THE HAMPDEN HIPPOCRAT, notify us in advance of an address change and include your zip code number.

Olsten Health Care
Home Health Care Services

WE MAKE HOUSE CALLS
Professional Care/Olsten Home Health Care Services Offers You:

- Free Patient Evaluation
- Complete Research into Insurance Coverage and Processing of subsequent claims
- Only experienced, screened and tested RNs, LPNs, Rehabilitative Therapists, Home Health Aides, Homemakers, Mental Health/Mental Retardation Workers
- Bonded, Liability Insured Employees
- Guaranteed Quality Service
- Care Custom Matched to the Patient's Needs
- Close Contact with Physicians
- Medicare/Medicaid Certified

For information or service requests, call
733-1132, 584-1030 or **567-1011.**

OLSTEN HealthCare

$ .....

THE BOTTOM LINE
IS GETTING PAID!

PAID FOR YOUR SERVICES • PRODUCTS

WE ENHANCE BOTTOM LINES
through professional
COLLECTION SERVICES

ETHICAL • EXPERIENCED • EFFICIENT
BONDED

for further information
785-5800

HART ADJUSTMENT BUREAU
1355 LIBERTY ST., SPFLD., MA 01104

From the Editors

This issue heads off with an article about current issues in surgical education. A former Hippocrat Editor, Dr. Nick Coe, is a co-author. Dr. Lorne Smith has offered a piece updating us on the "Hottest" news in General Surgery from the perspective of someone who has learned and performed laparoscope cholecystectomy more than 100 times in the first year of its availability in the Pioneer Valley. Finally we offer a commentary on town gown issues in General Surgery that some of you may have missed when it appeared in the surgical literature. ■

Brigid Glackin, M.D.
Donald J. Higby, M.D.
Co-editors

Smoke-Free Poster Contest— On Our Cover

The Hampden District Medical Society (HDMS), in support of the Springfield School's Third Grade "Smoke-Free Class of 2001" program, sponsored a poster contest in the schools to promote community awareness of this worthwhile cause. The contest, which began in March, drew participation from all thirty Springfield schools that house third grades bringing the number of entries to over 2000. Two hundred and forty Runner-up Winning Poster entries, eight from each of the 30 schools, were on exhibit in Baystate West's Center Court until April 29th. This project by HDMS was with the cooperation of The Springfield School Department, Marion Merrell Dow, Inc., The McDonald Corporation, Riverside Park, the American Lung Association, The American Heart Association, The American Cancer Society, and The HDMS Women's Auxiliary.

Jacqueline Tourigny from the Memorial School is the Grand Prize winner of the $200 U.S. Savings Bond. The Grand Prize Winning Poster (pictured on the cover) will be used by the media throughout the year to continue to enhance community awareness of the Springfield School's smoke-free goals. ■

Hampden Committee Activities

The Executive Committee discussed specific ongoing programs and events as well as new topics.

The "House Calls" program was aired on Sunday, March 29th. It was the second in a series of Public Awareness Programs presented by the HDMS in cooperation with Merck, Sharp and Dome on Channel 22. Merck, Sharp and Dome agreed to a grant of $10,000.00 for assistance in the production.

The Poster Contest began with the children of the 3rd grades of the Springfield schools making their posters from March 16th through April 10th. The winning posters from each school were exhibited from April 24th through the 29th. Marion-Merrell Dow increased their commitment to $2,500.00 this year.

The Legislative Breakfast was held on April 3rd at the Deliso Center of Mercy Hospital. Forty-six physicians and ten Legislators attended. The topics for discussion were the HIV Legislation presented by Dr. Richard Brown and the Mandatory Seat Belt Law presented by Dr. Timothy Emhoff. This law was discussed at the March 10th Legislative Committee meeting at the MMS. The vote was in favor of supporting mandatory seat belts. We also heard from Dr. Lorne Mednick concerning a bill to revamp the medical examiner system in the Commonwealth.

The speaker at the April 28th Annual Meeting was Mr. John Mroz, who made every effort to attend this meeting. He was in Berlin, Germany on April 27. If he was unable to attend his Executive Assistant, Mr. Alexander Bogomolov, would replace him.

A total of 42 physicians signed up for the MASSPRO meeting. This meeting was attended by Dr. Peter Maselli and other members of the MASSPRO Board.

Dr. Keenan reported that the director of the Westfield Boys Club asked him to orchestrate another Substance Abuse Program. The original program was held a year ago and was very successful.

The Health Access Task Force Committee met in February for the first time. Efforts were centered on infant mortality in Hampden County. ■

RUGS ORIENTAL
ANTIQUE and SEMI-ANTIQUE RUGS

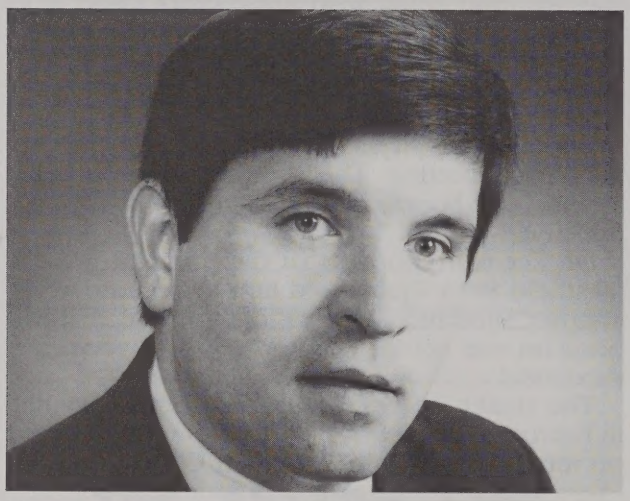
MARKARIAN & MARKARIAN
EST. 1895
472 BRIDGE STREET, SPRINGFIELD
at APREMONT TRIANGLE 737-1227
We buy and sell Oriental Rugs

AUTHENTIC OIL PAINTINGS
INDIAN and CHINESE RUGS

Message Center Beepers
1401 State Street, Springfield, MA 01109
Mobiletelephone ■ Beepers ■ Answering Service
781-1149 Mass Toll Free: 1-800-332-1149

The Enemy Is Us

This is my last shot. My term as HDMS President is over. Like Ted Williams, I would like to go out with the preverbial bang.



Mark J. Mullan, M.D., President

It's not easy to try to figure out what I want to leave as my final message to the masses. Anyone who has read my previous diatribes knows that I am one angry fellow. There are a myriad of problems with the health care system as we know it and this guy is fed up and frustrated and just about can't take it anymore.

In my nine short years post training, I've been involved in a number of health system related activities, from AMA delegate and HDMS President to the boards of IPA/HMOs and even of a hospital. After synthesizing all the ideas and thoughts that I have absorbed through this time, the ultimate, albeit, obvious answer to my epitaph jumps right out. I have met the enemy and it is us.

In different ways, and in different roles, all of us are guilty of poisoning the profession's relationships with patients, insurers, hospitals, the media, elected officials *and* even colleagues. An environment has been created which fosters discontent, unhappiness, early burnout, lack of communication and less than optimal patient care. This has led to a lack of any sort of a unified front which could, in the long run, help construct a new profession beneficial to MDs and patients alike.

This division in our core is a monstrous one. Everyone seems to have dug their own trench and only comes up for food and air. Often there is blatant disregard for the welfare of patients and other physicians while looking out only for Number One. A few examples, of many we could discuss, will suffice.

There are insurance company doctors, those who determine reimbursement and "appropriate" lengths of stay. Instead of actually reading the record or examining the patient, they obtain bits of information about a case from a nurse (who usually hasn't seen the patient either). Then, from some office in a high rise many miles away, they develop a strongly preconceived notion out of some computerized database and harasses the attending physician until the patient is discharged. The hope is not to see that the patient receives adequate care, it is only to save his/her employer a few bucks.

Medical directors of pre-paid health plans are cut from the same cloth. Under the guise of espousing "appropriate, cost-effective care", they often undercut physician-patient relationships in an attempt to improve the bottom line. Their phony concern for patients' well-being shows up frequently as rejected referrals, disallowed hospital stays and any excuse to refuse inpatient evaluation. They too have a strict, nearly religious belief in the fact that whatever averages, means and other data that the computers spit out are Gospel. And if the practitioner doesn't fit into the mold, he's a bad doc.

Then there are those doctors in the public eye who spew out propoganda which always seems detrimental to the reputation of physicians as a whole. From medical reporters and writers to government bureaucrats to the like of Sidney

Wolfe, the public is bombarded with negativity. They make a feeble attempt to say "all doctors aren't necessarily bad, but...". No wonder many patient mistrust us. And as the latest statistics show, malpractice suits are again on the rise.

I'm not going to let practicing physicians off the hook. Many serve on hospital boards and committees and rather than speaking out boldly on various policy and procedural issues, they kowtow to the majority. In doing so this either allows the status quo to florish or leads to policies detrimental to everyone and everything except the bottom line. In addition, physicians seem to be easy marks when it comes to allowing administrative types of all kinds to convince us, often with those dreaded computer stats, that certain behavior and/or practice patterns which our colleagues demonstrate are somehow inappropriate.

Examples of what we have allowed to happen abound. Subspecialty societies tend to fight hard to protect only their own, ignoring the needs of other physicians. Hospital administrators have created divisions in the ranks by creating a false loyalty truly based only on their own needs. A fictitious Maginot Line has been stuck between the private community, hospital based physicians and those on an HMO staff model situation. So instead of keeping our common goals and needs in mind, we tend to focus either on our own selfish wants or that of Big Brother.

Government agencies have been quick to capitalize on our tunnel vision. The RBRVS fiasco is only the most recent incident. Those who were predicted to benefit under this new reimbursement scheme are quick to grab a few bucks at the expense of their friends. Others saw it only as a devious plot which in the end would result only in a blank check to rob everyone involved. Guess who was right?

Rather than dwell on that and other atrocities, though, we must look ahead. Instead of focusing on what the bottom line will be on next year's tax return, we have to picture in our minds the year 2000 and ask ourselves what we would prefer the field of medicine to be like at that time. I guarantee that the only way we will preserve any semblance of professional independence from institutional and governmental interference will be to speak in one voice. This will be a singularly difficult task, but we have to examine our consciences deeply and begin to change our own behavior while reflecting on what is not only best for us but for our patients.

Either that or we shall hang separately. ■

WILL H.I.V. POSITIVE PHYSICIANS BE COVERED UNDER DISABILITY CONTRACTS?

Many of our clients are asking: *"What happens if I test H.I.V. positive? Even though I'm able to work, I may not be allowed to practice."*

"Will my disability carrier pay the claim? Will there be any surprise contingencies?"

Call us, in confidence, for information.

SINGER • POTITO
ASSOCIATES
Consultants to Professional Practices

Howard E. Singer
Michael A. Potito

26 Teaberry Lane, Amherst, MA 01002
117 Park Avenue, W. Springfield, MA 01089
256-1225 or 746-3100
FAX 253-5838

FOR MORE INFORMATION, CALL OUR OFFICES, MAIL OR FAX THIS FORM TO THE ABOVE.

NAME_____

STREET_____

CITY_____ STATE _____

ZIP_____ PHONE_____

"Changes and Challenges in Surgical Education"

Surgical education is as fascinating, dynamic and alarming an area to be involved with as any in medical pratice. Just as quantum leaps in technology threaten to change many areas of surgery beyond recognition and new and innovative methods of teaching and learning are discovered or rediscovered, the governing and legislative bodies are proposing changes in the funding of medical education that would equate the advent of endoscopic surgery to the significance of the introduction of another cephalosporin. Yet, if there is anything to learn from history, it is that dire predictions and the rantings of doomsayers are usually a catalyst. The stronger the smell of brimstone, the more ideas for solutions to problems appear. Some changes are inevitable. Those who accept change and change with it, will endure; those who resist will meet their metaphoric meteorite and join the ancient saurians.

Surgical education is as fascinating, dynamic and alarming an area to be involved with as any in medical practice.

In undergraduate education, innovations have occurred in programs striving to integrate basic science learning with clinical experiences. This need has been readily apparent to many of us for years, but acceptance and change have been slow to come. Perhaps more fundamental is the growing trend towards self-directed learning, of which problem based learning is one approach. Although the days of interminably boring lectures are not yet past, those days are numbered. Educational theory and practice readily demonstrate the ineffectiveness of this didactic approach. Perhaps a graphic analogy would be Pavlov's sham feeding experiments. Students readily learn that at the time of lectures they must ingest information, but it promptly disappears and gives no nourishment. Self directed learning puts the onus on the learner and fosters a continuing thirst for knowledge throughout a career in medicine.

Another area of undergraduate education that cries out for attention is the fourth year of medical school-the Montessori year or the year of free association. Not free of tuition fees of course, but to a large extent free of structure, direction, intent and purpose, and in large part free of any useful contribution to the general education of what the National Board of Medical Examiners calls a general, undifferentiated medical practitioner (GUMP, for those who like acronyms!). The year needs to become an educational experience with some guidance and meaning. Right now, it's largely a waste of time and money.

Graduate surgical education also faces many challenges. The trend in the last decade for prespecialty residents (Orthopedics, ENT, Neurosurgery and some Urology programs) to spend only one year in the specialty of General Surgery is of great concern to many of us who continue to believe that General Surgery still offers the most balanced and all encompassing education in the discipline of surgery. Many of us feel that all surgeons of whatever specialty need a grounding in the basics of surgery. Undergraduate education frequently abrogates this responsibility and it falls to the broad discipline of General Surgery to ensure that specialists and subspecialists (those who limit their practice to a single joint or organ) have an understanding of the human organism as a whole.

The major area of discussion in resident education has been how to train future surgeons

to perform uncommon or complex procedures. There are simply not enough abdomino-perineal resections, radical neck dissections or Whipple's to allow surgeons destined for thoracic or plastic surgery to do these during a residency. A new structure has therefore been proposed in which cardiothoracic and plastic surgical residents would complete four years of general surgical training and then leave to enter specialty residencies. This would enable general surgical residents to concentrate on an area of personal interest and thereby receive a more extensive experience in a particular area of surgery. Such a plan would require an alteration in the geometry of surgical programs, changing the last three years into two general surgical years for all residents followed by two more specialized years for those planning a career in general surgery. Meanwhile, the CT and plastic residents would be tracked into their own programs.

At the attending level, the last two years have seen what may be the greatest educational cooperation of the millenium. Suddenly tyros were tutoring elders, neophyte staff members found themselves cast in the role of preceptor and we all, masters and juniors alike, scrambled to keep up with what was not just another new fad, but a new era. Laparo-endoscopic surgery is here to stay. It has also proven a challenge to train the residents in these new techniques-they are often demonstrably more facile than those of us who did not train on Nintendo.

Surgical education is never boring. Sometimes it's frustrating, the responsibility may be frightening and it is often infuriating. The importance, however, is highlighted by the growing membership, importance and national influence of groups such as the Association for Surgical Education and the Association of Program Directors in Surgery. Both of these are actively researching new and innovative teaching techniques and ways to ensure an excellent education for tomorrow's surgeon. ■

Nicholas P.W. Coe, M.D., Baystate Medical Center and Parvis Sadighi, Berkshire Medical Center

For Sale: Examination room and waiting room furniture: used, but in good condition.

2 examination tables	2 end tables
2 treatment tables	1 Doctor's desk & chair
1 medicine cabinet	2 wait chairs
4 waiting room chairs	3 filing cabinets

Plus assorted other items and books!

Asking price $1,000.00 or best offer. Please call: **783-9222** after 6:00 p.m. Ask for Jackie.

WANT IT SOONER?

MEDICAL BILLING

Electronic & N.E.I.C. Processing

Our Specialty

Retiring Physicians: We'll take care of your accounts too!

PriMed Financial Services

Financing of patient self-pay balances

JJFlanaganAssociates, Inc.

130 Maple Street
Springfield, MA 01103
(413) 734-4542 • Fax (413) 732-1632

Laparoscopic Surgery

Lorne C. Smith, M.D., F.A.C.S., is former president of the Hampden District Medical Society and also a former Chief of Surgery and Medical Staff President/Holyoke Hospital.

The field of general surgery has changed dramatically in the past 2 to 3 years. The advent of the laparoscopic approach to a variety of problems within the purview of general surgery has been revolutionary. It was a remarkable event that almost all of the surgeons in the United States have learned to perform these new procedures and are now using them routinely.

There are between 600,000 and 700,000 cholecystectomies performed in the United States each year.

The area where the technique is used most commonly at this time, is biliary surgery, particularly cholecystectomy. There are between 600,000 and 700,000 cholecystectomies performed in the United States each year. At the present time, the vast majority are performed via the laparoscopic technique.

The technique involves creating a pneumoperitoneum with carbon dioxide and then performing the surgery using a laparascope with the image transmitted to a television monitor. The benefit to the patient is that the procedure involves much less pain and much less post-operative disability. Most patients are discharged within 24 to 48 hours and are able to resume normal activity within 7 days. The economic benefit in terms of society is obviously great.

In addition to cholecystectomy, a large number of other procedures are now being performed or being investigated. The following is a list which is not conclusive but merely the beginning.

1. Common duct exploration
2. Surveillance of the abdomen for staging of malignancy
3. Hernia repair
4. Appendectomy
5. Splenectomy
6. Repair of hiatus hernia
7. Procedures for the treatment of peptic ulcer disease
8. Evaluation of blunt trauma
9. Colon resection
10. Lysis of adhesions
11. Additional procedures limited only by imagination

A unique aspect of this rapidly developing

TOROS OMARTIAN & SON, Inc.
We Buy and Sell
ORIENTAL RUGS
286 Bridge Street
Tel: 736-1531
Open Thurs. til 9:00 p.m. *Free Parking Validated*

field is the fact that the development of the techniques and teaching of these skills came from the private community sector rather than the usual situation where surgical developments have come from the university centers. The university centers have, however, embraced the lapaoscopic techniques with equal enthusiasm.

Many of us, including this author, are concerned that there may be too much enthusiasm for these new techniques. Clearly, the situation is one where complications can occur and probably do occur at an incidence which is higher than was the case when all of these procedures were performed as open operations. Considerable attention is being paid to this and, hopefully, this situation will not last for long. In addition, there are many procedures that probably should not be performed by laparoscopy, at least in a routine sense. The current data would indicate that repair of inguinal hernias by laparoscopic technique must, at this point, be considered an experimental approach.

Procedures such as colon resection require a much longer operative period and also involve a small incision being made. The benefit of this approach to colon surgery remains to be seen.

There has been an explosive development in equipment design and manufacture which is also a little frightening. The latter concern is that the overall cost of these procedures is considerably more than was the case when they were performed with the routine reusable instruments. Most of the equipment here is disposable and quite expensive. The additional cost of a routine cholecystectomy, because of this, approaches the dollar savings of shorter hospitalization in some studies.

In conclusion, laparoscopic surgery is an exciting development in the field of general surgery which is evolving rapidly. The procedures are being performed with care and diligence at all of the hospitals in our area. The surgical community here can be very proud of these developments. ■

THE PHYSICIAN'S CHOICE IN HOMECARE!

IV THERAPY

- Antibiotics
- IgG
- Chemotherapy
- TPN
- Pain Management
- Enteral

RESPIRATORY THERAPY

- Oxygen
- Pentamidine
- Ventilators
- Suction
- Aerosol Compressors
- CPAP

PROTOCARE®

338 Birnie Avenue
Springfield, MA 01107
Telephone: 800-344-7146

Accredited by Joint Commission on Accreditation of Healthcare Organizations

The Town-Gown Syndrome
An Ancient Disease, as Yet Uncured

Reprinted with permission: Archives of Surgery, Volume 126, March 1991. 285-7.

The first cases of the so-called town-gown syndrome were alleged to have occurred in the 13th century, when the first universities were founded. Throughout the more or less civilized parts of Central and Western Europe, these institutions proliferated, creating the environment for frequent outbreaks of violence and rioting among students, faculty, and neighboring townspeople. During the next three or four centuries, the disease finally remitted as communities realized that having a university in their midst was not only an economic but an intellectual boom, and the students and faculty, although somewhat unruly, stopped laying waste to the adjacent villages (except for a few Ivy League universities).

The syndrome waned and largely disappeared in the rest of the civilized world, but, unfortunately, there has been a recent exacerbation of this troublesome ailment.[1] It is fair to say that the town-gown syndrome is essentially limited to the medical profession and is not observed in other disciplines characterized by graduate education and practice in communities, as exemplified by architecture, engineering, or even, strangely enough, law. It would be hard to conceive of any serious competition or hostility arising between those who teach these disciplines and those who practice them. Unfortunately, such is not the case in medicine, and the disease is as severe, or perhaps worse, in surgery as it is in other specialties.

It is important to define several types of the town-gown malady that are rampant in the United States, specifically with regard to epidemology. The first and least common, although sometimes significant, is the intramural conflict in universities that exists between the full- and part-time clinicians/teachers on the university faculty who teach and practice in the university hospital, and the research-oriented specialists in a clinical discipline coupled with basic scientists with neither interest nor skill in clinical medicine.[2] This illness is manifest openly in faculty appointments and promotions committees, resulting in two- or three-tiered faculty tracks that are based on professional activity rather than professional quality. This inevitably and regrettably results in a caste system with mutual disdain between the competent teacher/clinician and the renowned investigator. Department chairpersons and deans tend to contain these hostilities, although an undercurrent of feeling frequently persists in spite of protestations to the contrary.

A second expression of the syndrome, the simplest to comprehend, is the intensely competitive atmosphere that often pits teaching/university hospitals and community hospitals against each other. An unhealthy, expensive, and potentially destructive campaign to recruit patients is commonplace. This is reflected not only in the attitudes of both university and community physicians, but also in the attitudes of deans, department chairpersons, administrators, and marketers. As lasers, laparoscopic cholecystectomy, cardiac surgery, and other lucrative, highly technologic endeavors attract increasing attention from comptrollers and accountants in all hospitals, we must presume that institutional competition will intensify.

In all fairness, this competition is equally if not more keenly observed between community hospitals. Unfortunately, it is easier to identify the players when university location, faculty membership, and community hospital staff affiliation and loyalties are so readily apparent. It is important for all concerned to separate

institutional marketing initiatives from quality evaluation of physicians. High-quality patient care is provided in both arenas, and competition is now a way of medical life, not a cause for strife.

The third, and perhaps most subtle and troubling variation of all, is that which has sprung up in major community hospitals that have a strong dedication to teaching students and house officers. Departments of surgery in large community hospitals, heavily committed to providing high-quality tertiary care as well as maintaining strong teaching programs, have been required by surgical accrediting agencies to recruit fulltime salaried teaching staff members. Of the 280 surgical residencies in the United States, more than half are located in such major hospitals, almost all of which have some university ties, but all have as a primary focus the provision of high-quality patient care. Most of these hospitals have existed for decades, growing in size, complexity, and sophistication. Many surgical staff members were trained there and are now senior members of the teaching staff with full appreciation of the quality of their institution and a fierce loyalty to the system in which they gained expertise, ie, the fee-for-service, private practice setting.

Onto this scene, however, varying numbers of salaried teaching staff have recently been grafted. The current requirement that the Residency Review Committee in Surgery has instituted for salaried faculty numbers is that there shall be a salaried chairperson and one geographic full-time salaried surgeon for each chief resident graduating in any given year.[3] The majority of these programs graduate between two and six residents each year, and the advent of three to seven full-time salaried faculty members (or full-time equivalents for part-time faculty members) has created an intramural stratification of interests, motivation, and outlook that is the causative virus of the town-gown syndrome in major university-affiliated teaching hospitals.

Having been a close observer of and struggling therapist for all three types of town-gown syndrome, I find it difficult not to be persuaded that the third type is the most complex, wherein hospital salaried teaching staff and voluntary teaching staff coexist. Discussions with colleagues in similar settings in institutions from

Continued on next page

NOW, WE'RE CONVENIENT FOR YOUR CONNECTICUT PATIENTS TOO!!!

CHALLENGE

PHYSICAL THERAPY AND REHABILITATION, P.C.

Is Pleased to Announce the Opening of its FIFTH Office

157 Mountain Road, Suffield, Connecticut • (203) 668-7300

General Orthopedic Injuries
Knee & Shoulder Injuries
TMJ Dysfunctions
Work Related Injuries
Aquatic Therapy
Neck & Back Dysfunctions
Podiatric Dysfunctions
Sports Injuries
Ob/Gyn Related Problems
Pre-Natal Exercise Classes

71 Park Avenue
West Springfield
(413) 734-3269

171 Pine Street
Holyoke
(413) 536-7824

125 No. Main Street
Belchertown
(413) 323-9686

Work Re-Entry Center
53 Capital Dr., West Springfield
(413) 734-3355

The Town-Gown Syndrome

Continued from previous page

various parts of the country make the case that the problems are uncannily similar, with no geographic predilection. There are two basic issues from which conflict arises, both of which should be readily addressed, but neither of which is addressed with any frequency. The symptoms are frequently very subtle, may be hidden for periods, but then resurface, often in an explosive exacerbation of political activity, usually precipitated by minor stimuli.

Economic Conflict

The advent of a full-time faculty member cannot and would not, in and by itself, create anxiety on the part of the voluntary faculty, since it is crystal clear that effective administration and teaching leave so little time for patient care that the economic threat is essentially nonexistent. However, the subsequent need to recruit other full-time members to satisfy the requirements for maintaining modern surgical residency programs creates turmoil and lends credence to the most commonly enunciated concern of voluntary faculty; to wit, "This hospital is going into the private practice of medicine, and everyone will work for the hospital before long."

In fact, even when salaried teaching staff are added to other departments, the repercussions are often felt among voluntary surgical teaching faculty. They view the acquisition of new faculty members as further evidence that the private practice of surgery is being subverted to hospital control. Paradoxically, administrators see the educational enterprise as an inordinate expense that may require rethinking.

On the other hand, the salaried teaching faculty do develop a practice of some kind, sometimes because of pressure from the institution to help offset salaries and other teaching costs, but more frequently so that the teaching of surgery does not become a classroom exercise for the salaried faculty. Teaching surgical principles must be done at the bedside and in the operating room, where it properly belongs. Several surveys conducted in institutions with active teaching programs have shown that the advent of new faculty, specifically those with unique or special skills and training, increases the total number of patients in that discipline rather than resulting in salaried faculty providing care for patients previously treated by voluntary faculty. A standard formula has been developed, namely, any single practitioner of surgery contributes no more (and often less) than one patient per year to the teaching faculty's volume. The majority of patients whom the teaching surgeon treats are new patients from outside the community, indigent patients, or patients supported by public agencies for whom the payment for services is at an extremely low level.

Lack of Mutual Respect and Communication

Possibly the more basic area of conflict between the voluntary teaching faculty and the salaried teaching faculty is the unfortunate lack of mutual respect that is periodically, and sometimes consistently, demonstrated by both sides.[4] The salaried teaching faculty is made up of individuals who may have spent much, if not all their careers in the academic university setting with a major focus on teaching and research as well as patient care. These individuals often adhere to the interesting and erroneous tenet that the academic setting is the only place in which high-quality surgery is practiced.

The voluntary faculty, either for reasons of ingrained prejudice or in response to an accurate perception of the teaching faculty's attitudes, immediately dismisses the full-time faculty member as an individual with weak clinical skills, no real interest in patient welfare, and a dedication to travel, writing articles, and other nonclinical pursuits. Unfortunately, the house staff is the usual focal point for airing these views, although operating room nurses, administrators, and other more or less interested observers may also be subject to public airing of biases.

Obviously, neither attitude is correct; both are born of unreasonable prejudices that discredit the individual teacher, and the net effect is that internal strife is heightened. This is inimical to the health of the department, to the institution, and, most importantly, to the residents who are confused and often adversely affected by what is perceived as antagonism between two camps.

The cure is simple in concept but difficult to implement. The real tragedy is that both groups are dedicated to the same objectives, namely, to provide the highest quality patient care and the most effective milieu and substantial teaching program possible. Because both parties have the same objectives, it is difficult to comprehend why intelligent sugeons of good faith should not always be able to correct

Continued on the next page

the misperceptions and iron out their differences through open, frank communication.

The most important aspect of this form of the syndrome is the lack of mutual respect. Academicians can remain as academic as they like, administer departments in an effective way, and achieve all of the necessary goals to guarantee a highly effective and desirable residency training program, but they can only do so with the full cooperation and help of their community practitioner colleagues. In fact, the operative word is colleague, not adversary. The voluntary staff must play a major role in departmental administration and in setting teaching policy as well as having full responsibility for a very significant segment of the teaching load.

In most nonuniversity teaching hospitals, residents spend 75% or more of their time with the voluntary faculty from whom they learn much of their surgical technique (which is generally equal to and often superior to that found in university hospitals, not only because of the high volume of patients, but also because of the dedication demonstrated by voluntary teaching faculty in the operating room). On the other hand, the voluntary faculty must accept the notion that "the good old days," which really were not that good, are gone and that current concepts of surgical education require a major commitment to teaching basic science, to the application of basic science to clinical surgery (applied science), and to clinical and laboratory research. Teaching rounds, intensive care unit activities, and a number of other intellectual pursuits have reached the same importance in surgical education as have technical skills.

The solution to the financial competition issue, which on the surface appears to be important but from a logical standpoint is not, is less obvious. It is difficult not to be persuaded that large hospitals are anxious to increase their influence in the community to increase market share. In actuality, every hospital, including those currently showing a significant profit margin, anticipates diminishing revenues, higher costs, and shrinking endowments. As interest rates fall, so does the confidence of the concerned administrator in his or her ability to contain costs and ensure financial security for the future. Teaching programs are extremely

Continued on next page

Gary W. Lavallee

GIVE YOUR FINANCIAL NEEDS THE ATTENTION THEY DESERVE.

NE The New England®
Your Financial Partner

Gary W. Lavallee
117 Park Avenue
W. Springfield, MA 01089
(413) 781-5480

The Town-Gown Syndrome

Continued from previous page

expensive. Faculty salaries are an important component of those expenses, and it is highly unlikely that the institution wants to expand its influence into the private practice of medicine. Some institutions have expanded into primary care satellite or outreach sites, especially with joint ventures with physicians, but relatively few are proving to be really profitable, and all have the major purpose of filling hospital beds. The latter goal, bringing more patients into the hospital, will be of benefit to all surgical practitioners, whether voluntary or salaried.

The town-gown syndrome has reached areas in American surgery that were immune 20 years ago, having developed in major community hospitals as a result of national trends in surgical education. The two groups must learn to live with and respect each other or the surgical educational enterprise will be limited to university hospitals to the detriment of the entire system. This would change the entire flavor of surgical education and, of course, would have a negative impact on the quality of patient care offered by community teaching hospitals. In fact, there is little question that the volume of surgery in all university hospitals could not begin to provide a reasonable experience for the number of surgeons required; clearly, the wealth of clinical material available to surgical trainees and nontechnical standpoint cannot be duplicated within universities alone.[5] It is certainly high time for each group to recognize the other's worth and for the disease to be eradicated by mutual concern, respect, and free and intelligent interchange of ideas. ■

Robert J. Baker, M.D.
Wilmington, Del

References

1. Wescoe WC. The town-gown syndrome: pathology. JAMA. 1963;186:785-786.
2. Harbinson SP. Fragmentation. *Arch Surg.* 1964;89:1-6.
3. *Essentials of Accredited Residencies:New General Surgery Special Requirements.* Accreditation Council on Graduate Medical Education;1990.
4. Petersdorf RG. The town-gown syndrome. JAMA. 1987;257:2478-2479.
5. Cohn I Jr. Sugical education and the community hospital. *Am Surg.* 1973;39:537-542.

New directions

New innovations

S T A R T ..... Providing Comprehensive Health Care.

PHYSICAL THERAPY
Individualized treatment programs plus recommendations for home exercise and injury prevention.

SPORTS THERAPY
Care and Prevention of sports injuries for people who want an accelerated return to peak performance.

EQUIPMENT SALES
Whether your needs are clinical or fitness related, our staff is qualified to find the equipment that fits your requirements.

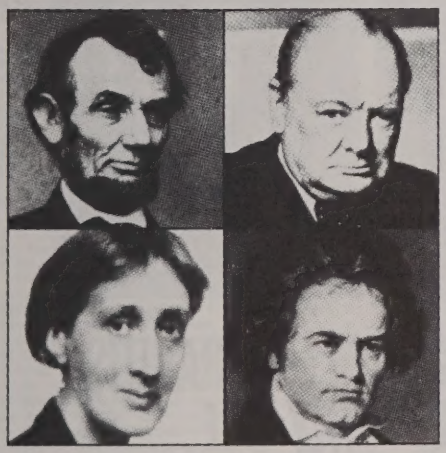
FITNESS EVALUATION & PRESCRIPTION
Sports specific or general fitness programs highlighting Women's Diet & Exercise, Cardiovascular Health, Strength Training, and Body Toning.

RETURN-TO-WORK PROGRAM
Therapy and education to assure quick recovery and reduce risk of reinjury. Special programs in Back Care and Cumulative Trauma Syndrome.

CORPORATE HEALTH
Programs designed for a company's work force to promote wellness and healthy lifestyles. Specialists in Work Site Analysis and Ergonomics.

Physical Therapy • Sports Medicine
S · T · A · R · T
Comprehensive Health Systems

CORPORATE	46 Daggett Place (413) 734-8801	**NATICK**	67 Union Street (508) 653-3400
FEEDING HILLS	60 N. Westfield St. (413) 786-8908	**SPRINGFLD**	3400 Main St. (413) 788-6195
FRAMINGHAM	21 Blandin Avenue (508) 875-3888	**WILBRAHAM**	2377 Boston Rd (413) 596-2424



An Emotional Crisis Can Happen To Anyone. When It's Your Patient, Call Us.

History tells us that Abe Lincoln, Winston Churchill, Virginia Woolf and Beethoven all experienced manic-depressive or schizophrenic behavior during their lifetimes.

Even hard-working, successful adults can experience an emotional crisis. Where do you turn when depression, anxiety or stress make it impossible for one of your patients to cope? Who can you rely on when someone you have been caring for is seriously emotionally impaired?

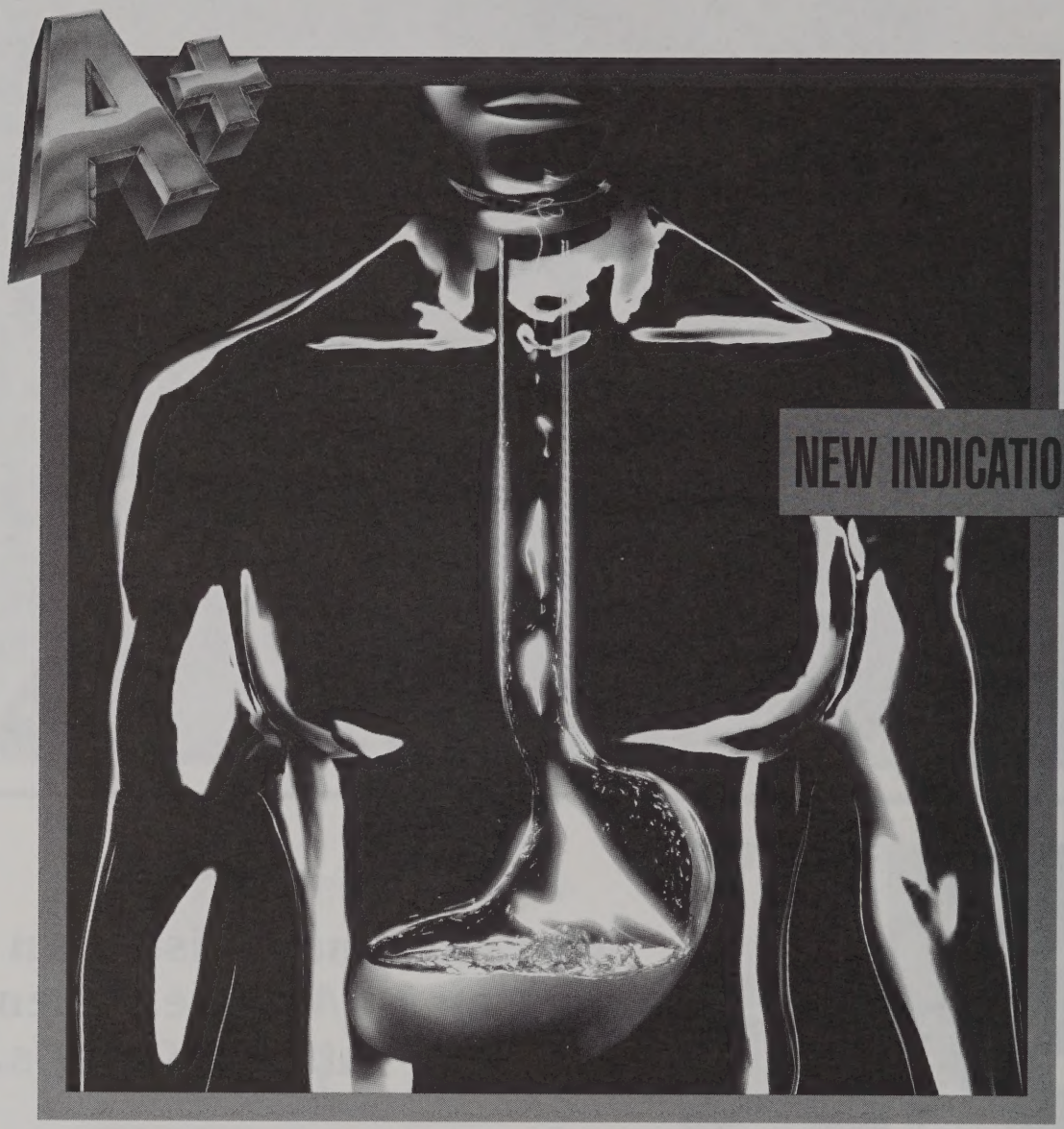
The Cooley Dickinson Hospital Psychiatric Program is experienced at helping primary care providers by providing comprehensive diagnostic and treatment services.

Short-stay inpatient treatment in our safe, supportive atmosphere has helped many adults overcome their emotional crisis and get their lives back in order.

For more information about Cooley Dickinson's Psychiatric Program, call 582-2500 and take the first step toward assisting one of your patients in getting back on track.

The Cooley Dickinson Hospital

Psychiatric Program
30 Locust St. (Rt. 9) ■ P.O. Box 5001
Northampton, MA 01060-5001 ■ (413) -582-2500



ONLY ONE H_2-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.[1]

AXID®
nizatidine
150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

1. Data on file, Lilly Research Laboratories.

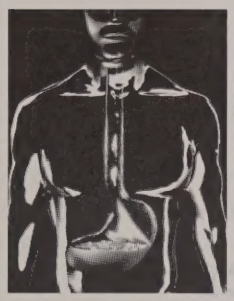
See accompanying page for prescribing information.

© 1991, ELI LILLY AND COMPANY

NZ-2948-B-249305

AXID®

nizatidine capsules



Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug.

Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

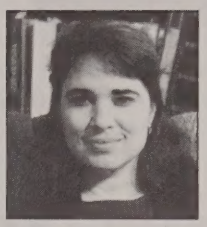
Lilly

Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2948-B-249305

© 1991, ELI LILLY AND COMPANY

Editor's Comment



Marla Ruth Allison, J.D., L.I.C.S.W. was the author of Recognizing Signs of Child Abuse: History in Adult Patients. (Hippocrat March/April 1992.) She works in the Outpatient Psychiatry Service at Baystate Medical Center and welcomes contact there from interested professionals. Phone: 736-7601. ■

ESTABLISHED IN THE YEAR 1881

Dickinson-Streeter Funeral Service, Inc.

305 State Street - Springfield, MA 01105
Telephone (413) 733-2129

ALFRED J. GAY
President

JAMES C. GAY
Vice President

NEW MEDICAL OFFICE SPACE IMMEDIATELY AVAILABLE

Prime Location
Across The Street From
Providence Hospital
+
Convenient Access To
Routes 5, 91, 291, 391 &
The Massachusetts Turnpike
+
Modern Attractive Building
+
Space Flexible – Up To
10,000 Square Feet
+
FREE PARKING

CALL 413-539-2407

Trust Your Partner

New financial strategies can protect PC buy-ins and payouts from the 1990 Tax Act.

Mr. Singer and Mr. Potito are recognized authors and speak frequently to associations, medical groups and medical schools about subjects pertaining to: "How To Negotiate The Most Lucrative Financial Arrangement When You Buy-In or Sell Your Interest In A Medical Practice". The authors have expressed interest in conducting a seminar on this subject for the Hampden District Medical Society. If there is interest from our members, contact Carol Nystrom at our Society's office, 736-0661.

Lorne C. Smith, M.D., Chairman
Insurance Committee

In highly competitive areas like New York, doctors in medical partnerships are increasingly frustrated as they realize that their ownership interest may be in jeopardy. It has become clear that more practices are breaking apart because active partners are unwilling to pay retiring partners the "value" of their shares.

Now the pressure is even greater as a result of the new provisions for medical practices detailed in the Tax Act of 1990. But with some understanding, immediate action and an appropriate funding strategy in place, medical partnerships can avoid the high cost of noncompliance and reduce the tension among partners. Even more important, partners can be assured that each will receive a substantial payout for their shares at retirement or before.

First, it's important to grasp what it means to evaluate a medical partnership. There are at least six valuation methods commonly used by accountants who specialize in medical partnerships. But regardless of which valuation method chose, business value is by definition a very gray area. The primary assets of real value in a medical partnership are the partners themselves. The income generated by each professional is a result of that professional's qualifications, knowledge, skills, reputation and contacts. Because the tangible assets held by medical partnerships are typically small, income is usually related to the

How the IRS benefits from the 1990 Tax Act

Assume the cost to purchase the shares from a retiring partner is $250,000. If your professional corporation (P.C.) could deduct the cost of the shares in the form of a consulting or deferred compensation agreement, using a combined federal and state tax bracket of 43 percent, the following would result:

Cost of Shares	$250,000
Tax Deduction:	-107,500
Net After Tax Cost:	142,500

Now look at the substantial gain to the IRS as a result of the new reporting requirements in the Tax Act of 1990:

The P.C. Must Earn	$438,596
And Pay Tax of:	-188,596
To Pay Share Price of	250,000

As you can see, the IRS is highly motivated because it can now collect $188,596 in taxes from a typical buy-out procedure in a medical practice.

dedicated efforts of the professional partners.

All the evaluation methods commonly used, however, are moot, because in the long run the practice's worth to the retiring partner is the amount partners can and will pay to the exiting partner.

The most appropriate financial approach is to create a funding method that is tax-advantaged, which is protected from creditors and which creates the necessary capital to virtually guarantee all partners that they receive their expected payout and that the cash will be available at the right time.

It is important to examine the traditional buy-in, buy-out procedure and also to understand why the 1990 Tax Act impacts the physician's business. These preliminaries then allow partners to initiate a funding approach that will not violate current code.

Traditionally, the buying into and selling out of a medical practice worked in the following manner: A new associate, burdened with debt from medical school, would require help puchasing his shares in the practice. To accommodate him, the practice partners might take the partner's ownership out of salary. For example they might pay the newcomer eighty thousand of his or her hundred-thousand-dollar salary and use the withheld twenty thousand per year to pay for shares.

At the other end of the career trajectory, the practice might pay out a retiring partner by offering him or her a consulting contract or a deferred compensation program. These methods allowed the new associate to purchase shares with "pre-tax" dollars and permit the business to take a deduction for the amount it pays to the retired consultant.

The Tax Act of 1990 now forces medical partnerships to reexamine the entire buy-in and buy-out procedure. Here's why: From now on, medical partnerships will have to tell the IRS whenever there's a ten percent or larger transfer of shares in a medical practice and whenever a new employment agreement is signed. These new reporting requirements are, from the IRS angle, a way to curb abuses of using pre-tax dollars to buy in and out of practice. From now on, the IRS will know, through the reporting, what you are doing. It will be examining how your medical partnership structures the transfer of ownership interest to new partners and to retiring partners to determine if sufficient taxes have been paid.

Continued on next page

SEE MORE PATIENTS AND LEAVE YOUR BILLING TO US.

- Are you suffering from billing and collection problems?
- Would you like to devote more of your time to medicine and get rid of the hassle of dealing with the ever-changing coding and reimbursement procedures at Medicare and Medicaid?

If the answers to these questions are yes, and you are concerned about the state of your accounts receivable and the future of your practice, it is time to talk to Sivek Associates. Sivek is a total Medical Billing/Accounts Receivable Management Service. We are completely up-to-date with both Medicaid and Medicare, as well as all other private insurance companies. We are an EMC vendor and are on average 95% accurate with first time claim submissions.

If you're hurting, Sivek Associates, Inc. can Help!

Sivek Associates, Inc.

"Professional Medical Billing Services since 1974"

200 North Main Street, Suite 1103 ▪ East Longmeadow, MA 01028
Telephone: (413) 525-6611

Trust Your Partner

Continued from previous page

Traditional financing methods, therefore, may no longer be viable. Look at it this way: When was the last time you bought a share of IBM with pre-tax dollars? The IRS is asking the same of you when you transfer shares in your practice (See chart).

Partners entering practice and those who remain after a partner retires will need to pay for shares with more costly, after-tax dollars. As this fact is more widely acknowledged, doctors will be asking themselves, "is there a way to pay less, or balance this new expense, by maximizing ownership value when I sell?" At the same time, doctors will want to be paid without having to worry about unnecessary entanglements with the IRS.

Even under the new reporting requirements, there are ways to be sure that your future payout is secure. It's key that partners must be able to discuss the ownership transfer issue among themselves. Members of the practice should discuss ways to assure each other that the monies promised at retirement for ownership interest will be available and that these payouts will not cause undue strain on the remaining partners.

Think about how to pre-fund necessary amounts so each partner has his or her share "on account" upon exiting the practice. This can be accomplished by setting up one or more specialized trusts. The monies allocated by the practice to these trusts could be tax deductible for the business if set up appropriately and could offer a high line of resistance in the event of a liability suit.

Key objectives that should be achieved are:

1. To establish a program that complies with the tax law.

2. To use reliable financing methods that take advantage of a business deduction so monies may be set aside to pre-fund future buyouts.

3. To assure that monies set aside compound tax-deferred or tax-free.

4. Perhaps most important, to do everything possible to insure that the monies set aside have maximum protection against any lawsuits that might arise from malpractice.

Regarding these objectives, it is vital to think long-term. Achieve the goal of long-term security along with the most effective financial program, and your practice will have many advantages over the competition.

First, every partner will enjoy a new sense of security. The critical issue of ownership interest will be funded so that everyone is assured of being paid a fair share. Moreover, since the fund is set up to be flexible, it may provide a much larger payout to each partner than anticipated. The remaining partners will not have to dig into their own pockets and withdraw a lump sum when a partner retires in the future.

Secondly, the best talent will have the opportunity to enter into a practice whose business thinking is far ahead of the competition. The new associate will be told up front that his or her potential for recieving a substantial payout for ownership interest is much more likely to occur in a practice that has established IRS-acceptable funding methods for future share redemptions. Remember, a successful practice needs to attract the best talent. In the long run, younger partners assure that retiring partners get paid for their shares.

We're not saying that the establishment of a clear strategy as we've discussed is easy. It may take the help of a specialized consultant to bring the members of the group through the process of understanding the tax law and agreeing on a future value that is realistic. It will be necessary to work with advisors who understand not only the communication process, but who are also current in financing techniques for medical practices using various specialized trusts that work under the umbrella of the Tax Act of 1990.

No matter how many consultants advise you, however, the fate of your practice is ultimately in your own hands. It only makes sense that you understand the issues involved and become an active participant in the planning process. The decisions you make today will undoubtedly have a dramatic effect on the long-term health of your business and the amount of money you are paid when you exit. ■

Singer/Potito Associates is a consulting firm specializing in compensation planning and financing techniques for medical practices. Their offices are located in Amherst and West Springfield, Massachusetts.

A Simple Pledge

That we will provide patients with quality care, at the fairest cost, under the strictest of ethics, and the highest standards.

Medical Personnel Pool®
A Medicare certified Home Health Agency
RN/LPN/HHA IV Therapy Intermittant/Long term

959 Main Street
Springfield
734-6900

90 Conz Street
Northampton
586-7365

ANNOUNCING A NEW SOLUTION TO COLLECTION PROBLEMS!

Guaranteed fast payments - electronically - direct to doctors from patients' bank accounts.

HBS
HEALTHCARE BUSINESS SERVICES
OF NEW ENGLAND

200 NORTH MAIN STREET #14 • EAST LONGMEADOW, MA 01028
PHONE: 413-525-7445 • FAX: 413-525-8238

• SPECIALIZING IN ELECTRONIC CLAIMS PROCESSING •

In Memoriam

Dr. Joseph Hahn, retired chief of neurosurgery at Baystate Medical Center in Springfield, died there Tuesday March 31, 1992. He was 83. Hahn was born in Boston, and graduated from Tufts Medical School in Medford. He interned at Springfield Hospital, the precursor to Baystate Medical, and completed his neuro-surgical training at Boston City Hospital. He began practicing in Springfield in 1936 as the only neurosurgeon then in Western Massachusetts. He subsequently was named chief of neurosurgery at BMC, and served in that post until his retirement in 1980. He was a principal of the Neurosurgical Group, which he helped to establish in 1966. He was a major in the Army Medical Corps. in the European theater during World War II, and saw action in the Battle of the Bulge and the Phillipines. He returned to Springfield in 1946 to resume his surgical practice. He was a member of the Phi Lambda Kappa medical fraternity, and served as clinical professor of neurosurgery at tufts Medical School. He was a member of the Hampden District Medical Society and the American Medical Association. Dr. Hahn leaves his wife of 54 years, the former Sybil Berish of Longmeadow; a son, Dr. Richard Hahn of Durham, N.H.; a daughter, Donna H. Labovitz of Longmeadow, and six grandsons.

Dr. Richard A. Lavin, 66 of Longmeadow, an anesthesiologist at Providence Hospital in Holyoke for 30 years, died Thursday March 26, 1992 at Sarasota Memorial Hospital. He was on vacation in Florida. He was born in East Liverpool, Ohio, and graduated from the University of Pittsburgh. He served in the Army during the Korean War, and received a Silver Star for heroism. He was a resident of this town for 30 years, and a member of Sinai Temple, its Brotherhood, and the Maimonides Association. He was a past president of the Crestview Country Club in Agawam. He leaves his wife, Zelma (Schmidt) Lavin of Longmeadow; three sons, Robert of Springfield, James of Long Island, N.Y., and Dr. William Lavin of Kettering, Ohio, and eight grandchildren. ■

From the MMS Regional Office

The 1992 elections are upon us. Never before has health care been such an important issue or has your role as a physician been clearer. As the debate around health-care reform escalates and the number of players multiplies, it is essential that physicians become active participants in the political process.

To help our members become involved with these important elections, the Massachusetts Medical Society is developing a special political education program, Election '92. Although the Massachusetts Medical Society is a non-partisan organization and does not support or endorse any candidate or party, it is our responsibility to teach individual physicians how to become involved and to keep them informed of important events and activities. Election '92 will bring you information on the candidates' positions on health care, voter registration kits, issue briefs and other key materials. Staff are also available to meet with districts, specialty societies and other groups to help get out the vote. If you have any questions or want more information, please do not hesitate to contact me, 1-800/322-2303, ext. 1196.

Important Election Dates This Year

August 18, 1992—Last day to register to vote in state primaries and to change party enrollment; September 15, 1992—Massachusetts state primary; October 6, 1992—Last day to register to vote in presidential and state elections; November 3, 1992—Election Day.

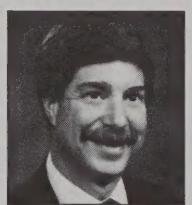
For more information on voting call: Office of Massachusetts Secretary of State 1-800/462-VOTE.

MMS Department of Specialty Society Relations and Political Education 1-800/322-2303, ext 1136. ■

Alex Calcagno, Director
Specialty Society Relations & Political Education

ARE YOU CONCERNED ABOUT

- the impact of the medicare-medicaid anti-kickback regulations on your daily practice?
- the tax treatment of employees versus independent contractors?
- structuring employment, partnership and shareholder agreements for group practices?
- malpractice claims due to inadequate informed consent?
- reducing estate taxes, and protecting assets from creditors' claims?
- providing for the orderly disposition of your practice in the event of death or disability?



Attorney
Arthur W. Price

Arthur W. Price and Michele J. Feinstein, partners in Cohen, Rosenthal, Price, Mirkin & Wernick, have more than twenty-five years of combined experience in representing area physicians in their practices and individually. They counsel solo and group practices in their day to day businesses as well as in their planning for growth or extraordinary concerns. They also advise physicians on personal and family problems.

Call Arthur W. Price or Michele J. Feinstein to discuss your practice or personal concerns. We're here to help.

Attorney
Michele J. Feinstein

COHEN, ROSENTHAL, PRICE, MIRKIN & WERNICK, P.C.
ATTORNEYS AT LAW

One Monarch Place, Suite 1300, Springfield, MA 01144-0001
Tel.: (413) 781-0471 Fax: (413) 734-9013

New Members Welcome

Dennis W. Owens, M.D.
Mercy Hospital
271 Carew Street
Springfield, MA 01104

Born: October 10, 1952
Premed: Harvard University, 1970-1974
Medical: University of California, San Diego 1974-1978
Internship: Memorial Hospital, Worcester, MA 1978-1979
Residency: University of Massachusetts Medical Center 1978-1979
Baystate Medical Center June 1982-October 1982
Specialty: Emergency Medicine

Dionysios K. Veronikis, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 6, 1958
Premed: Moravian College, Pennsylvania 1977-1982
Medical: University of Patras School of Medicine 1982-1988 Greece
Internship: Morristown Memorial Hospital, New Jersey 1990-1991
Residency: Baystate Medical Center 1991-Present
Specialty: Obstetrics/Gynecology
Resident

Robert S. Wool, M.D.
Noble Hospital
115 West Silver Street
Westfield, MA 01085

Born: July 12, 1958
Premed: Hamilton College, New York 1976-1980
Medical: Bowman Gray School of Medicine 1980-1984
Residency: Hartford Hospital 1984-1988
Specialty: Obstetrics/Gynecology

Stephen A. Metz, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 14, 1945
Premed: Massachusetts Institute of Technology 1963-1970
Medical: University of Maryland School of Medicine 1974-1978
Internship: National Naval Medical Center 1978-1979
Residency: National Naval Medical Center 1979-1982
Fellowship: University of Louisville School of Medicine 1987-1988
Specialty: Obstetrics/Gynecology

Loring S. Flint, Jr., M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: May 25, 1952
Premed: Boston University 1970-1973
Medical: Boston University School of Medicine 1972-1976
Internship: Michael Reese, Chicago, Illinois 1976-1977
Residency: Michael Reese 1977-1978 (Internal Medicine); Boston City Hospital 1978-1979 (Pediatrics); Michael Reese 1979-1980 (Internal Medicine)
Specialty: Internal Medicine

Glen P. Bombardier, M.D.
10 Hospital Drive
Holyoke, MA 01040

Born: June 19, 1952
Premed: University of Massachusetts 1970-1974
Medical: Albany Medical School, New York 1974-1978
Internship: St. Mary's Hospital 1978-1979
Residency: St. Mary's Hospital 1979-1981
Specialty: Internal Medicine

Continued on next page

New Members Welcome

Continued from previous page

Aaron T. Gelfand, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: September 27, 1956
Premed: McGill University, Canada 1980-1982 Concordia University, Canada 1976-1979
Medical: University of Guadalajara 1985-1987 Mt. Sinai School of Medicine 1988-1991
Internship: Baystate Medical Center 1991-Present
Specialty: Obstetrics/Gynecology
Resident

John A. Dawson, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 25, 1949
Premed: Alfred University, New York 1967-1971
Medical: Royal College of Surgeons, Dublin, Ireland 1972-1977
Internship: Royal College of Dublin 1972-1977
Residency: Kingston General Hospital, England 1977-1978; New York Medical College 1979-1982; Westchester County Medical Center, New York 1982-1983
Fellowship: New York Medical College 1983-1984
Specialty: Surgical Critical Care/Burn Care Surgery

David S. Knierim, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: December 28, 1946
Premed: Andrews University, Michigan 1964-1967; Loma Linda University, California 1973-1974
Medical: Loma Linda University School of Medicine, CA 1975-1978
Internship: University of California/Long Beach VA Hospital 1978-1979
Residency: Loma Linda University Medical Center 1979-1984
Fellowship: The Hospital for Sick Children, Toronto 1984
Specialty: Neurological Surgery/Pediatric Neurological Surgery

George A. Kohake, M.D.
Laurel Street
Longmeadow, MA 01106

Born: July 15, 1954
Premed: Kansas University 1976
Medical: Kansas University 1979
Internship: University of Missouri Consortium of Hospital 1980-1983
Residency: University of Missouri Consortium of Hospital 1980-1983
Specialty: Emergency Medicine

Attention All Physicians

The Naval Reserve Center located on Westover Air Force Base is in need of a contract physician to provide physical examinations to both prospective and current Reserve personnel assigned to this command. These services would ideally be performed at the Reserve Center during one four hour period, one weekend a month. Please contact Petty Officer Lamothe at 593-5777 with any information or questions.

D.W. Costa, Commanding Officer

570 Cottage Street
P.O. Box 51947
Springfield, MA
01151-5947

VNA
VISITING NURSE ASSOCIATION
of PIONEER VALLEY, *Inc.*
SINCE 1914
BRINGING HEALTH HOME
for GENERATIONS

HOME
HEALTH
SERVICES
24 hours a day
7 days a week

781-5070
V/TDD Access For The Hearing Impaired

Serving the Communities of Agawam, Chicopee, East Longmeadow, Hampden, Longmeadow, Ludlow, Springfield, Southwick, Westfield, West Springfield, and Wilbraham.

Certified for Medicare, Medicaid

United Way Agency

Hampden District Medical Society Sponsored Insurance Programs

- 5 Year Renewable Group Term Life
  ($600,000 Maximum)
- Disability Income
  ($1,500 Weekly Maximum)
  with
  Residual Benefit
  and COLA Benefit
  GUARANTEED Renewable/Convertible
- Office Overhead
  ($20,000 monthly)
  New Maximum)

For details call (617) 426-0020

LB
personal service
since 1922

LESTER L. BURDICK, INC.

Loyalty Group Insurance

10 POST OFFICE SQUARE, BOSTON, MA 02109 • (617) 426-0020

Underwrtten by Commercial Life Insurance Company, 15 Corporate Place South, Piscataway, NJ 08854 • (908) 562-2400

Vanguard
Medical Management Services

Reimbursement Quiz

(Please check True or False)

T	F	
☐	☐	Coding, billing and reimbursement are our easiest tasks
☐	☐	Adjusting to RBRVS was easy
☐	☐	We enjoy maintaining multiple sets of procedure codes
☐	☐	We look forward to another computer system upgrade
☐	☐	Our claims are never arbitrarily denied
☐	☐	We enjoy hearing "All our agents are busy now, please hold"
☐	☐	Insurance carriers are always consistent in handling our claims
☐	☐	It's getting easier to control the business side of our practice

If you answered the questions *"True"*
we'd really like to talk to you,
if not,
you should be talking to us.

We Solve Reimbursement Problems

Vanguard Medical Management Services
512 West Main Street • Shrewsbury, MA 01545-2253

(508) 842-4947 • (800) 743-2888